House of Representatives

General Assembly

File No. 378

January Session, 2013

Substitute House Bill No. 6612

House of Representatives, April 4, 2013

The Committee on Insurance and Real Estate reported through REP. MEGNA of the 97th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE HEALTH INSURANCE GRIEVANCE PROCESS FOR ADVERSE DETERMINATIONS, THE OFFICE OF THE HEALTHCARE ADVOCATE AND MENTAL HEALTH PARITY COMPLIANCE CHECKS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (38) of section 38a-591a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(38) "Urgent care request" means a request for a health care service or course of treatment (A) for which the time period for making a non-urgent care request determination **[**(A)**]** (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or **[**(B)**]** (ii) in the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested, (B) for a substance use disorder, as

described in section 17a-458, or for a co-occurring mental disorder, or (C) for a mental disorder, (i) inpatient services, (ii) partial hospitalization, as defined in section 38a-496, or (iii) intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.

Sec. 2. Subsections (a) to (c), inclusive, of section 38a-591d of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) (1) Each health carrier shall maintain written procedures for (A) utilization review and benefit determinations, (B) expedited utilization review and benefit determinations with respect to prospective urgent care requests and concurrent review urgent care requests, and (C) notifying covered persons or covered persons' authorized representatives of such review and benefit determinations. Each health carrier shall make such review and benefit determinations within the specified time periods under this section.

(2) In determining whether a benefit request shall be considered an urgent care request, an individual acting on behalf of a health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any benefit request (A) determined to be an urgent care request by a health care professional with knowledge of the covered person's medical condition, or (B) specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as amended by this act, shall be deemed an urgent care request.

(b) With respect to a nonurgent care request:

(1) (A) For a prospective or concurrent review request, a health carrier shall make a determination within a reasonable period of time appropriate to the covered person's medical condition, but not later than fifteen calendar days after the date the health carrier receives such request, and shall notify the covered person and, if applicable, the covered person's authorized representative of such determination,

whether or not the carrier certifies the provision of the benefit.

(B) If the review under subparagraph (A) of this subdivision is a concurrent review request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall be continued without liability to the covered person for the duration of such review or any grievance filed by the covered person or the covered person's authorized representative pursuant to section 38a-591e, as amended by this act, or 38a-591f, as amended by this act, of an adverse determination or a final adverse determination of such concurrent review.

(2) For a retrospective review request, a health carrier shall make a determination within a reasonable period of time, but not later than thirty calendar days after the date the health carrier receives such request.

(3) The time periods specified in subdivisions (1) and (2) of this subsection may be extended once by the health carrier for up to fifteen calendar days, provided the health carrier:

(A) Determines that an extension is necessary due to circumstances beyond the health carrier's control; and

(B) Notifies the covered person and, if applicable, the covered person's authorized representative prior to the expiration of the initial time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(4) (A) If the extension pursuant to subdivision (3) of this subsection is necessary due to the failure of the covered person or the covered person's authorized representative to provide information necessary to make a determination on the request, the health carrier shall:

(i) Specifically describe in the notice of extension the required information necessary to complete the request; and

(ii) Provide the covered person and, if applicable, the covered person's authorized representative with not less than forty-five

calendar days after the date of receipt of the notice to provide the specified information.

(B) If the covered person or the covered person's authorized representative fails to submit the specified information before the end of the period of the extension, the health carrier may deny certification of the benefit requested.

(c) With respect to an urgent care request:

(1) (A) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination and except as specified under subparagraph (B) of this subdivision, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than seventy-two hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments;

(B) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, for an urgent care request specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as amended by this act, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than twenty-four hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

(2) (A) If the covered person or the covered person's authorized representative has failed to provide information necessary for the

health carrier to make a determination, the health carrier shall notify the covered person or the covered person's representative, as applicable, as soon as possible, but not later than twenty-four hours after the health carrier receives such request.

(B) The health carrier shall provide the covered person or the covered person's authorized representative, as applicable, a reasonable period of time to submit the specified information, taking into account the covered person's medical condition, but not less than forty-eight hours after notifying the covered person or the covered person's authorized representative, as applicable.

(3) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of its determination as soon as possible, but not later than forty-eight hours after the earlier of (A) the date on which the covered person and the covered person's authorized representative, as applicable, provides the specified information to the health carrier, or (B) the date on which the specified information was to have been submitted.

Sec. 3. Subsection (e) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(e) Each health carrier shall provide promptly to a covered person and, if applicable, the covered person's authorized representative a notice of an adverse determination.

(1) Such notice **[**may**]** shall be provided in writing or by electronic means and shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

(A) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount;

(B) The specific reason or reasons for the adverse determination, including, upon request, a listing of any clinical review criteria,

including professional criteria and medical or scientific evidence and a description of the health carrier's standard, if any, that [was] were used in reaching the denial;

(C) Reference to the specific health benefit plan provisions on which the determination is based;

(D) A description of any additional material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim;

(E) A description of the health carrier's internal grievance process that includes (i) the health carrier's expedited review procedures, (ii) any time limits applicable to such process or procedures, (iii) the contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and (iv) a statement that the covered person or, if applicable, the covered person's authorized representative is entitled, pursuant to the requirements of the health carrier's internal grievance process, to [(I) submit written comments, documents, records and other material relating to the covered person's benefit request for consideration by the individual or individuals conducting the review, and (II)] receive from the health carrier, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the covered person's benefit request;

(F) If the adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request, and instructions for requesting such copy;

(G) If the adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the adverse determination and (i) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances or (ii) a statement that an explanation will be provided to the covered person free of charge upon request, and instructions for requesting a copy of such explanation; **[**and**]**

(H) A statement explaining the right of the covered person to contact the commissioner's office or the Office of the Healthcare Advocate at any time for assistance or, upon completion of the health carrier's internal grievance process, to file a civil suit in a court of competent jurisdiction. Such statement shall include the contact information for said offices; **[**.**]** and

(I) A statement that if the covered person or the covered person's authorized representative chooses to file a grievance of an adverse determination, (i) such appeals are sometimes successful, (ii) such covered person or covered person's authorized representative may benefit from free assistance from the Office of the Healthcare Advocate, which can assist such covered person or covered person's authorized representative with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time, (iii) such covered person or covered person's authorized representative is entitled and encouraged to submit supporting documentation for the health carrier's consideration during the review of an adverse determination, including narratives from such covered person or covered person's authorized representative and letters and treatment notes from such covered person's health care professional, and (iv) such covered person or covered person's authorized representative has the right to ask such covered person's health care professional for such letters or treatment notes.

(2) Upon request pursuant to subparagraph (E) of subdivision (1) of

this subsection, the health carrier shall provide such copies in accordance with subsection (a) of section 38a-591n.

Sec. 4. Subdivision (3) of subsection (c) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of a concurrent review urgent care request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

Sec. 5. Subsection (d) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(d) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative, in writing or by electronic means, of its decision within a reasonable period of time appropriate to the covered person's medical condition, but not later than:

(A) For prospective review and concurrent review requests, thirty calendar days after the health carrier receives the grievance;

(B) For retrospective review requests, sixty calendar days after the health carrier receives the grievance; **[**and**]**

(C) For expedited review requests, except as specified under subparagraph (D) of this subdivision, seventy-two hours after the health carrier receives the grievance; **[**.**]** and

(D) For expedited review requests of a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as amended by this act, twenty-four hours after the health carrier receives the grievance.

(2) The time periods set forth in subdivision (1) of this subsection shall apply regardless of whether all of the information necessary to make a decision accompanies the filing.

Sec. 6. Subsection (d) of section 38a-591f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(d) (1) The written decision issued pursuant to subsection (c) of this section shall contain:

(A) The titles and qualifying credentials of the individual or individuals participating in the review process;

(B) A statement of such individual's or individuals' understanding of the covered person's grievance;

(C) The individual's or individuals' decision in clear terms and the health benefit plan contract basis for such decision in sufficient detail for the covered person to respond further to the health carrier's position;

(D) Reference to the documents, communications, information and evidence used as the basis for the decision; and

(E) For a decision that upholds the adverse determination, a statement (i) that the covered person may receive from the health carrier, free of charge and upon request, reasonable access to and copies of, all documents, communications, information and evidence regarding the adverse determination that is the subject of the final adverse determination, and (ii) disclosing the covered person's right to contact the commissioner's office or the Office of the Healthcare Advocate at any time, and that such covered person may benefit from free assistance from the Office of the Healthcare Advocate, which can assist such covered person with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time. Such disclosure shall include the contact information for said offices.

(2) Upon request pursuant to subparagraph (E) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (b) of section 38a-591n.

Sec. 7. Subdivision (1) of subsection (i) of section 38a-591g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(i) (1) The independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision to uphold, reverse or revise the adverse determination or the final adverse determination, not later than:

(A) For external reviews, forty-five calendar days after such organization receives the assignment from the commissioner to conduct such review;

(B) For external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, twenty calendar days after such organization receives the assignment from the commissioner to conduct such review;

(C) For expedited external reviews, except as specified under subparagraph (D) of this subdivision, as expeditiously as the covered person's medical condition requires, but not later than seventy-two hours after such organization receives the assignment from the commissioner to conduct such review; **[**and**]**

(D) For expedited external reviews involving a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as amended by this act, as expeditiously as the covered person's medical condition requires, but not later than twenty-four hours after such organization receives the assignment from the commissioner to conduct such review; and

[(D)**]** (E) For expedited external reviews involving a determination

that the recommended or requested health care service or treatment is experimental or investigational, as expeditiously as the covered person's medical condition requires, but not later than five calendar days after such organization receives the assignment from the commissioner to conduct such review.

Sec. 8. Subdivision (7) of section 38a-591a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(7) "Clinical peer" means a **[**physician or other**]** health care professional who (A) holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and (B) for a review concerning a child or adolescent substance use disorder treatment, as such disorder is described in section 17a-458, or a child or adolescent mental disorder, holds a national board certification in child and adolescent psychiatry or child and adolescent psychology, and has training or clinical experience in the treatment of child and adolescent substance use or child and adolescent mental disorder, as applicable.

Sec. 9. Section 38a-591c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) (1) Each health carrier shall contract with (A) health care professionals to administer such health carrier's utilization review program, **[**and oversee utilization review determinations,**]** and (B) **[**with**]** clinical peers to conduct utilization reviews and to evaluate the clinical appropriateness of an adverse determination.

(2) (A) Each utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically by the health carrier's organizational mechanism specified in subparagraph (F) of subdivision (2) of subsection (c) of section 38a-591b to assure such program's ongoing effectiveness. A health carrier may develop its own clinical review

criteria or it may purchase or license clinical review criteria from qualified vendors approved by the commissioner. Each health carrier shall make its clinical review criteria available upon request to authorized government agencies.

(B) Notwithstanding subparagraph (A) of this subdivision, for any utilization review for the treatment of a substance use disorder, as described in section 17a-458, the clinical review criteria used shall be: (i) The most recent edition of the American Society of Addiction Medicine's Patient Placement Criteria; or (ii) clinical review criteria that are (I) developed as required under state law, and (II) reviewed and accepted by the Department of Mental Health and Addiction Services for adults and the Department of Children and Families for children and adolescents, as adhering to the prevailing standard of care.

(C) A health carrier that uses clinical review criteria as set forth in subparagraph (B)(ii) of this subdivision shall create and maintain a document that (i) compares each aspect of such clinical review criteria with the American Society of Addiction Medicine's Patient Placement Criteria, and (ii) provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the American Society of Addiction Medicine's Patient Placement Criteria.

(D) Notwithstanding subparagraph (A) of this subdivision, for any utilization review for the treatment of a mental disorder, the clinical review criteria used shall be: (i) For children and adolescents, the most recent guidelines in the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument; or (ii) clinical review criteria that are (I) developed as required under state law, and (II) reviewed and accepted by the Department of Mental Health and Addiction Services for adults and the Department of Children and Families for children and adolescents, as adhering to the prevailing standard of care.

(E) A health carrier that uses clinical review criteria as set forth in

subparagraph (D)(ii) of this subdivision for children and adolescents shall create and maintain a document that (i) compares each aspect of such clinical review criteria with the guidelines in the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument, and (ii) provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the guidelines in the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument.

(b) Each health carrier shall:

(1) Have procedures in place to ensure that (A) the health care professionals administering such health carrier's utilization review program are applying the clinical review criteria consistently in utilization review determinations, and (B) the appropriate or required clinical peers are being designated to conduct utilization reviews;

(2) Have data systems sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively;

(3) Provide covered persons and participating providers with access to its utilization review staff through a toll-free telephone number or any other free calling option or by electronic means;

(4) Coordinate the utilization review program with other medical management activity conducted by the health carrier, such as quality assurance, credentialing, contracting with health care professionals, data reporting, grievance procedures, processes for assessing member satisfaction and risk management; and

(5) Routinely assess the effectiveness and efficiency of its utilization review program.

(c) If a health carrier delegates any utilization review activities to a utilization review company, the health carrier shall maintain adequate

oversight, which shall include (1) a written description of the utilization review company's activities and responsibilities, including such company's reporting requirements, (2) evidence of the health carrier's formal approval of the utilization review company program, and (3) a process by which the health carrier shall evaluate the utilization review company's performance.

(d) When conducting utilization review, the health carrier shall (1) collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination, and (2) ensure that such review is conducted in a manner to ensure the independence and impartiality of the **[**individual or individuals**]** clinical peer or peers involved in making the utilization review or benefit determination. No health carrier shall make decisions regarding the hiring, compensation, termination, promotion or other similar matters of such **[**individual or individuals**]** clinical peer or peers based on the likelihood that the **[**individual or individuals**]** clinical peer or peers will support the denial of benefits.

Sec. 10. Section 38a-591e of the general statutes, as amended by sections 4 and 5 of this act, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) (1) Each health carrier shall establish and maintain written procedures for (A) the review of grievances of adverse determinations that were based, in whole or in part, on medical necessity, (B) the expedited review of grievances of adverse determinations of urgent care requests, including concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility, and (C) notifying covered persons or covered persons' authorized representatives of such adverse determinations.

(2) Each health carrier shall file with the commissioner a copy of such procedures, including all forms used to process requests, and any subsequent material modifications to such procedures.

(3) In addition to a copy of such procedures, each health carrier shall file annually with the commissioner, as part of its annual report required under subsection (e) of section 38a-591b, a certificate of compliance stating that the health carrier has established and maintains grievance procedures for each of its health benefit plans that are fully compliant with the provisions of sections 38a-591a to 38a-591n, inclusive, as amended by this act.

(b) (1) A covered person or a covered person's authorized representative may file a grievance of an adverse determination that was based, in whole or in part, on medical necessity with the health carrier not later than one hundred eighty calendar days after the covered person or the covered person's authorized representative, as applicable, receives the notice of an adverse determination.

(2) For prospective or concurrent urgent care requests, a covered person or a covered person's authorized representative may make a request for an expedited review orally or in writing.

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of the **[**individual or individuals**]** clinical peer or peers involved in making the review decision.

(B) If the adverse determination involves utilization review, the health carrier shall designate an appropriate clinical peer or peers to review such adverse determination. Such clinical peer or peers shall not have been involved in the initial adverse determination.

(C) The **[**individual or individuals**]** clinical peer or peers conducting a review under this section shall take into consideration all comments, documents, records and other information relevant to the covered person's benefit request that is the subject of the adverse determination under review, that are submitted by the covered person or the covered person's authorized representative, regardless of whether such information was submitted or considered in making the initial adverse

determination.

(D) Prior to issuing a decision, the health carrier shall provide free of charge, by facsimile, electronic means or any other expeditious method available, to the covered person or the covered person's authorized representative, as applicable, any new or additional documents, communications, information and evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such documents, communications, information, evidence and rationale shall be provided sufficiently in advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized representative, as applicable, a reasonable opportunity to respond prior to such date.

(2) If the review under subdivision (1) of this subsection is an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the covered person's authorized representative, as applicable, by telephone, facsimile, electronic means or any other expeditious method available.

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of a concurrent review urgent care request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

(d) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative, in writing or by electronic means, of its decision within a reasonable period of time appropriate to the covered person's medical condition, but not later than:

(A) For prospective review and concurrent review requests, thirty calendar days after the health carrier receives the grievance;

(B) For retrospective review requests, sixty calendar days after the health carrier receives the grievance; and

(C) For expedited review requests, twenty-four hours after the health carrier receives the grievance.

(2) The time periods set forth in subdivision (1) of this subsection shall apply regardless of whether all of the information necessary to make a decision accompanies the filing.

(e) (1) The notice required under subsection (d) of this section shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

(A) The titles and qualifying credentials of the **[**individual or individuals**]** clinical peer or peers participating in the review process;

(B) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, if applicable, the health care professional and the claim amount;

(C) A statement of such **[**individual's or individuals'**]** clinical peer's or peers' understanding of the covered person's grievance;

(D) The **[**individual's or individuals'**]** clinical peer's or peers' decision in clear terms and the health benefit plan contract basis or scientific or clinical rationale for such decision in sufficient detail for the covered person to respond further to the health carrier's position;

(E) Reference to the evidence or documentation used as the basis for the decision;

(F) For a decision that upholds the adverse determination:

(i) The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(ii) Reference to the specific health benefit plan provisions on which the decision is based;

(iii) A statement that the covered person may receive from the health carrier, free of charge and upon request, reasonable access to and copies of, all documents, records, communications and other information and evidence not previously provided regarding the adverse determination under review;

(iv) If the final adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (I) the specific rule, guideline, protocol or other similar criterion, or (II) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the final adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request and instructions for requesting such copy;

(v) If the final adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the final adverse determination and (I) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances, or (II) a statement that an explanation will be provided to the covered person free of charge upon request and instructions for requesting a copy of such explanation;

(vi) A statement describing the procedures for obtaining an external review of the final adverse determination;

(G) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

(H) A statement disclosing the covered person's right to contact the

commissioner's office or the Office of the Healthcare Advocate at any time. Such disclosure shall include the contact information for said offices.

(2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (b) of section 38a-591n.

(f) (1) Whenever a health carrier fails to strictly adhere to the requirements of this section with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review, regardless of whether the health carrier asserts that it substantially complied with the requirements of this section, or that any error it committed was de minimis.

(2) A covered person who has exhausted the internal grievance process of a health carrier may, in addition to filing a request for an external review, pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal grievance process that would yield a decision on the merits of the claim.

Sec. 11. Subsection (a) of section 38a-591d of the general statutes, as amended by section 2 of this act, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) (1) Each health carrier shall maintain written procedures for (A) utilization review and benefit determinations, (B) expedited utilization review and benefit determinations with respect to prospective urgent care requests and concurrent review urgent care requests, and (C) notifying covered persons or covered persons' authorized representatives of such review and benefit determinations. Each health carrier shall make such review and benefit determinations within the specified time periods under this section.

(2) **[**In determining whether a benefit request shall be considered an urgent care request, an individual acting on behalf of a health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any**]** Any benefit request (A) determined to be an urgent care request by a health care professional with knowledge of the covered person's medical condition, or (B) specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as amended by this act, shall be deemed an urgent care request.

Sec. 12. Subsection (c) of section 38a-591*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(c) To be eligible for approval by the commissioner, an independent review organization shall:

(1) Have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in section 38a-591g, as amended by this act, that include, at a minimum:

(A) A quality assurance mechanism in place that ensures:

(i) That external reviews and expedited external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(ii) (I) The selection of qualified and impartial clinical peers to conduct such reviews on behalf of the independent review organization and the suitable matching of such peers to specific cases, and (II) the employment of or the contracting with an adequate number of clinical peers to meet this objective;

(iii) The confidentiality of medical and treatment records and clinical review criteria;

(iv) That any person employed by or under contract with the

independent review organization adheres to the requirements of section 38a-591g, as amended by this act; and

(B) A toll-free telephone number to receive information twenty-four hours a day, seven days a week, related to external reviews and expedited external reviews and that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours;

(2) Agree to maintain and provide to the commissioner the information set forth in section 38a-591m;

(3) Not own or control, be a subsidiary of, be owned or controlled in any way by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care professionals; and

[(4) Assign as a clinical peer a health care professional who meets the following minimum qualifications:

(A) Is an expert in the treatment of the covered person's medical condition that is the subject of the review;

(B) Is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(C) Holds a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review; and**]**

[(D) Has**]** (4) Assign as a clinical peer a health care professional who has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question as to the clinical peer's physical,

mental or professional competence or moral character.

Sec. 13. Section 38a-478*l* of the general statutes is amended by adding subsection (e) as follows (*Effective October 1, 2013*):

(NEW) (e) The commissioner shall analyze annually the data submitted under subparagraphs (E) and (F) of subdivision (1) of subsection (b) of this section for the accuracy of, trends in and statistically significant differences in such data among the health care centers and licensed health insurers included in the consumer report card. The commissioner shall investigate any such differences to determine whether further action by the commissioner is warranted.

Sec. 14. Section 38a-1040 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

As used in sections 38a-1040 to 38a-1050, inclusive:

(1) "Consumer" means an individual who receives or is attempting to receive services from a managed care organization and is a resident of this state, or such individual's authorized representative, as defined in section 38a-591a, as amended by this act.

(2) "Managed care organization" means an insurer, health care center, hospital **[**or**]** service corporation, medical service corporation or other organization delivering, issuing for delivery, renewing, **[**or**]** amending or continuing any individual or group health managed care plan in this state.

(3) "Managed care plan" means (A) a product offered by a managed care organization that provides for the financing or delivery of health care services to persons enrolled in the plan through: **[**(A)**]** (i) Arrangements with selected providers to furnish health care services; **[**(B)**]** (ii) explicit standards for the selection of participating providers; **[**(C)**]** (iii) financial incentives for enrollees to use the participating providers and procedures provided for by the plan; or **[**(D)**]** (iv) arrangements that share risks with providers, provided the organization offering a plan described under subparagraph **[**(A), (B),

(C) or (D)**]** (A)(i), (A)(ii), (A)(iii) or (A)(iv) of this subdivision is licensed by the Insurance Department pursuant to chapter 698, 698a or 700 and that the plan includes utilization review, as defined in section 38a-591a, as amended by this act; or (B) a health insurance policy or health care plan that provides coverage of the types specified in section 38a-469.

Sec. 15. Section 38a-1046 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

Each employer **[**, other than a self-insured employer,**]** that provides health insurance or health care benefits to employees shall obtain from the Healthcare Advocate and post, in a conspicuous location, a notice concerning the services that the Healthcare Advocate provides.

Sec. 16. (*Effective from passage*) (a) Not later than September 1, 2013, the Insurance Commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health on the method the Insurance Department shall use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under its jurisdiction. In selecting such method, the commissioner shall examine and assess for fitness the methods set forth by the United States Department of Labor and URAC, in addition to any other methods discovered by or brought to the attention of the Insurance Department. As part of the evaluation process, the commissioner shall hold at least one public meeting at which stakeholders, including, but not limited to, relevant state agency personnel, health insurance companies and the general public, are invited to share their input and propose other compliance check methods.

(b) The report under subsection (a) of this section shall describe and address the comments shared at the public meeting or meetings, include an assessment of each potential method examined and append written comments and suggestions of the Healthcare Advocate.

(c) On or before October 1, 2013, the commissioner shall begin such compliance checks using the compliance check method selected.

Sec. 17. Section 38a-478a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

On March first annually, the Insurance Commissioner shall submit a report to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance, concerning the commissioner's responsibilities under the provisions of sections 38a-478 to 38a-478u, inclusive, 38a-479aa, 38a-591a to 38a-591h, inclusive, and 38a-993. The report shall include: (1) A summary of the quality assurance plans submitted by managed care organizations pursuant to section 38a-478c along with suggested changes to improve such plans; (2) suggested modifications to the consumer report card developed under the provisions of section 38a-478*l*; (3) a summary of the commissioner's procedures and activities in conducting market conduct examinations of utilization review companies and preferred provider networks, including, but not limited to: (A) The number of desk and field audits completed during the previous calendar year; (B) a summary of findings of the desk and field audits, including any recommendations made for improvements or modifications; (C) a description of complaints concerning managed care companies, and any preferred provider network that provides services to enrollees on behalf of the managed care organization, including a summary and analysis of any trends or similarities found in the managed care complaints filed by enrollees; (4) a summary of the complaints concerning managed care organizations received by the Insurance Department's Consumer Affairs Division and the commissioner under section 38a-591g, as amended by this act, including a summary and analysis of any trends or similarities found in the complaints received; (5) a summary of any violations the commissioner has found against any managed care organization or any preferred provider network that provides services to enrollees on behalf of the managed care organization; **[**and**]** (6) a summary of the issues discussed related to health care or managed care organizations

at the Insurance Department's quarterly forums throughout the state; and (7) a summary of the method used by the department to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under its jurisdiction, and results of such compliance checks.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2013*	38a-591a(38)
Sec. 2	*October 1, 2013*	38a-591d(a) to (c)
Sec. 3	*October 1, 2013*	38a-591d(e)
Sec. 4	*October 1, 2013*	38a-591e(c)(3)
Sec. 5	*October 1, 2013*	38a-591e(d)
Sec. 6	*October 1, 2013*	38a-591f(d)
Sec. 7	*October 1, 2013*	38a-591g(i)(1)
Sec. 8	*July 1, 2014*	38a-591a(7)
Sec. 9	*July 1, 2014*	38a-591c
Sec. 10	*July 1, 2014*	38a-591e
Sec. 11	*July 1, 2014*	38a-591d(a)
Sec. 12	*July 1, 2014*	38a-591l(c)
Sec. 13	*October 1, 2013*	38a-478*l*
Sec. 14	*October 1, 2013*	38a-1040
Sec. 15	*October 1, 2013*	38a-1046
Sec. 16	*from passage*	New section
Sec. 17	*October 1, 2013*	38a-478a

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 14 $	FY 15 $
Insurance Department	IF - Cost	Potential	Potential

Municipal Impact: None

Explanation

This bill specifies several requirements concerning the Insurance Department's oversight of compliance with the mental health parity laws. The bill requires the department to perform an evaluation process to select a compliance check method and to begin using the method selected by October 1, 2013. Should the check method selected be more labor intensive than the methods currently utilized by the department, additional administrative costs may result. However, as the method selected cannot be known in advance, the extent of these potential costs is unknown.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 6612

AN ACT CONCERNING THE HEALTH INSURANCE GRIEVANCE PROCESS FOR ADVERSE DETERMINATIONS, THE OFFICE OF THE HEALTHCARE ADVOCATE AND MENTAL HEALTH PARITY COMPLIANCE CHECKS.

SUMMARY:

This bill makes various changes to the health insurance grievance process for adverse determinations (e.g., claims denials). It treats requests for certain services or treatments for mental or substance use disorders as urgent care requests. As a result, it reduces the time insurers or other health carriers have to (1) make initial determinations on claims for these services and treatments and (2) act on requests to review adverse determinations. It specifies the clinical review criteria that must be used in any benefit determination or utilization review regarding the treatment or provision of services for such disorders.

Under current law, a person acting on behalf of an insurer must apply a prudent layperson's judgment to determine whether a benefit request should be considered urgent. But if the request is from a health care professional who (1) knows the condition of a covered person (e.g., an insured) and (2) deems the request to be urgent, it must be treated as such. Starting July 1, 2014, the bill eliminates the prudent layperson standard and deems as urgent those (1) judged urgent by the health care professional or (2) dealing with the specified services for mental or substance use disorders.

The bill expands the notice that carriers must provide a covered person and his or her authorized representative when the carrier makes an adverse determination or upholds this determination after review. For some non-urgent care requests, it requires that a treatment be continued without liability to the covered person while an adverse

determination is appealed, as is already the case with urgent requests.

By law, carriers must contract with clinical peers to evaluate the clinical appropriateness of adverse determinations. The bill additionally requires that clinical peers review all adverse determinations based at least in part on medical necessity, rather than just those involving utilization review. It requires clinical peers to have additional qualifications.

The bill expands the (1) role of the Office of the Healthcare Advocate (OHA) and (2) applicability of the requirement that employers post a notice concerning OHA.

By law, the insurance commissioner must prepare an annual consumer report card that, among other things, addresses managed care organizations and mental health services. The bill requires the commissioner to annually analyze this data for the accuracy of, trends in, and statistically significant differences in the data among the health care centers and health insurers included in the report card. It requires him to investigate such differences to determine whether he should take further action.

Additionally, the bill requires:

1. the Insurance Commissioner, by September 1, 2013, to report to the Insurance and Public Health committees on how the Insurance Department will check the compliance with state and federal mental health insurance parity laws;

2. the commissioner to begin the compliance checks using the selected method by October 1, 2013; and

3. the department's annual report to the Insurance and Public Health committees to summarize the method it uses to check for compliance and the results of the compliance checks.

Lastly, the bill makes minor and technical changes.

EFFECTIVE DATE: Upon passage for the commissioner's compliance report; October 1, 2013 for the provisions on mental and substance use disorders, adverse determination notices, and the OHA; and July 1, 2014 for the provisions dealing with clinical peers, utilization reviews, and the prudent layperson standard.

REQUEST FOR MENTAL OR SUBSTANCE USE DISORDER SERVICES

Benefit Determination

By law, the amount of time a carrier has to make a benefit determination depends on whether or not it is an urgent request. In general, carriers must make a determination with 15 calendar days for non-urgent requests but within 72 hours for urgent requests.

The bill treats as urgent requests, those for a service or treatment for (1) substance use disorder or co-occurring mental disorder and (2) inpatient services, partial hospitalization, or intensive outpatient services needed to keep a covered person from requiring in inpatient setting in connection with a mental disorder.

It requires the carrier to make its determination as soon as possible, but no more than 24 hours after it receives a request for service or treatment for these disorders. If the request is to extend a course of treatment beyond the initial period or number of treatments, the request must be made at least 24 hours before the initial authorization runs out. The 24-hour deadline for the carrier does not apply if the covered person or his or her representative fails to provide the information the carrier needs to make its determination.

Expedited Reviews

By classifying requests for these services and treatments as urgent, the bill entitles the covered person to an expedited review of an adverse determination. Under current law, the carrier or independent review organization must notify the covered person and his or her representative of its decision regarding an expedited review within 72 hours of receiving a grievance. The bill requires that carriers make

their decision for expedited reviews of requests for services and treatment for the mental and substance use disorders within 24 hours.

Utilization Review

By law, each carrier must contract with health care professionals to administer its utilization review program. Utilization review is the use of formal techniques to monitor the use of health care services or evaluate their medical necessity, appropriateness, efficacy, or efficiency.

Under current law, each program must use documented clinical review criteria based on sound clinical evidence. The bill requires that, for any utilization review or benefit determination for treating a substance use disorder, the program use the following criteria:

1. the most recent edition of the American Society of Addiction Medicine's Patient Placement Criteria or

2. clinical review criteria that are developed as required under state law and reviewed and accepted by the Department of Mental Health and Addiction Services (DMHAS) for adults and the Department of Children and Families (DCF) for children and adolescents, as adhering to the prevailing standard of care.

A carrier that uses criteria developed pursuant to state law must create and maintain a document that:

1. compares each aspect of these criteria with the society's patient placement criteria and

2. provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from those criteria.

For any utilization review or benefit determination for treating a mental disorder, the criteria must be:

1. for children and adolescents, the most recent guidelines in the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument or

2. clinical review criteria that are developed as required under state law, and reviewed and accepted by DMHAS or DCF as applicable, as adhering to the prevailing standard of care.

A carrier that uses criteria developed pursuant to state law for children and adolescents must create and maintain a document that

1. compares each aspect of the criteria with the guidelines in the academy's instrument and

2. provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the guidelines in this instrument.

ADVERSE DETERMINATIONS

Initial Adverse Determination Notices

By law, each carrier must promptly notify a covered person and, if applicable, his or her authorized representative, of an adverse determination. The bill additionally requires the notice to list, upon request, any clinical review criteria (including professional criteria) and medical or scientific evidence used to reach a denial.

By law, the notice must describe the carrier's internal grievance procedures. Under current law, this description must state that the covered person or his or her representative can submit written comments, documents, records, and other material regarding the request for the individuals conducting the review. The bill instead requires the notice to include a statement that, if the covered person or his or her representative chooses to grieve an adverse determination, that:

1. such appeals sometimes succeed;

2. the covered person or his or her representative may benefit from free assistance from OHA, which can help with a grievance;

3. the covered person or representative is entitled and encouraged to submit supporting documentation for the carrier to consider during the review of an adverse determination, including their narratives describing the problem, when the problem arose, the symptoms, and letters and treatment notes from the covered person's health care professional; and

4. the covered person or his or her representative has the right to ask his or her health care professional for these letters and treatment notes.

Reviews

By law, the covered person or his or her representative can grieve an adverse determination. Under the bill, if the decision in a review of a case that is not based on medical necessity upholds the adverse determination, the notice of the decision must include a statement disclosing:

1. the covered person's right to contact the insurance commissioner's office or OHA at any time,

2. that the covered person may benefit from free assistance from OHA, which can help him or her file a grievance, and

3. the contact information for the offices.

Continuing Treatment While Determination Is Appealed

Under the bill, if a non-urgent request is a concurrent review request, as defined by federal law (i.e., one that takes place when the service is being requested), the treatment must be continued without liability to the covered person during the review or any grievance filed by a covered person or his or her representative of an adverse determination or a final adverse determination of the concurrent

review. Existing law has a similar requirement in the case of urgent requests.

Clinical Peers

By law, carriers must contract with clinical peers to evaluate the clinical appropriateness of adverse determinations. The bill additionally requires that clinical peers be used to review all adverse determinations based at least in part on medical necessity.

The bill requires that carriers contract with clinical peers to conduct utilization reviews, rather than requiring them to contract with health care professionals to oversee the determinations in these reviews. It requires the clinical peers to participate in various stages of the review process.

The bill requires certain clinical peers to have additional qualifications. Under current law, clinical peers are health care professionals who hold a non-restricted license in any state in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

For a review or benefit determination concerning a substance use disorder treatment or mental disorder in a child or adolescent, the clinical peer must (1) hold a national board certification in child and adolescent psychiatry or child and adolescent psychology and (2) have training or clinical experience in treating child and adolescent substance use or mental disorder, as applicable.

The bill requires that each carrier have procedures to ensure that the appropriate or required clinical peers are designated to conduct utilization reviews.

The bill eliminates the requirement that, in order to be approved by the commissioner, an independent organization that reviews adverse determinations must assign as a clinical peer a health care professional who:

1. is an expert treating the covered person's medical condition that is the subject of the review;

2. is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person; and

3. holds a nonrestricted license in a state and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review.

The changes in the qualifications for clinical peers described above apply to the clinical peers assigned by these organizations.

OFFICE OF THE HEALTH CARE ADVOCATE

Role

The bill expands the role of OHA by expanding the definition of "consumer," "managed care organization," and "managed care plan."

By law, OHA can assume a wide range of responsibilities regarding the plans that managed care organizations provide to consumers. These include:

1. helping consumers select managed care plans and understand their rights and responsibilities under them,

2. helping consumers file appeals with managed care organizations, and

3. pursuing administrative remedies on behalf of consumers.

The bill expands the definition of:

1. "consumer" to include his or her authorized representative,

2. "managed care plan" to include policies or plans that cover all types of health insurance regulated by the Insurance

Department,

3. "managed care organization" to include organizations that continue individual or group managed care plans (the law already covers organizations that deliver, renew, or amend such plans).

Employer Notices

The bill applies the requirement that employers post a notice concerning the services OHA provides to (1) self-insured employers and (2) all employers that provide health care benefits to their employees. By law, employers that provide health insurance to their employees must post such notices.

REPORTS ON MENTAL HEALTH PARITY AND COMPLIANCE CHECKS

By September 1, 2013, the bill requires the insurance commissioner to report to the Insurance and Public Health committees on the method the Insurance Department will use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under its jurisdiction. In selecting the method, the commissioner must (1) examine the methods developed by the U.S. Department of Labor and URAC (an accreditor of health care organizations) and other methods discovered by or brought to the department's attention and (2) determine how well they work.

As part of the evaluation process, the commissioner must hold at least one public meeting where stakeholders can share their input and propose other compliance check methods. The stakeholders must at least include relevant state agency personnel, health insurance companies, and the general public.

The report must describe and address the comments shared at the meetings, assess each potential method examined, and append written comments and suggestions of the Healthcare Advocate.

By October 1, 2013, the commissioner must begin the compliance

checks using the selected method.

The bill also requires that the department's annual report to the Insurance and Public Health committees include (1) a summary of the method the department uses to check for compliance with state and federal mental health parity laws and (2) results of these checks.

BACKGROUND

Related Bills

SB 599, favorably reported by the Insurance and Real Estate Committee (file number 5), requires health insurers to authorize an insured's pharmacy to fill a prescription if the insured or his or her authorized representative files a grievance or requests a review of an adverse determination or final adverse determination related to dispensing a drug prescribed by a licensed participating provider.

HB 6517, favorably reported by the Program Review and Investigations Committee, among other things includes the same mental health compliance check provisions as in this bill. It also requires the Insurance Department to request the U.S. Department of Health and Human Services to rule on whether external appeal applicants must provide either an adverse determination notice, an insurance identification card, or both, and act accordingly in response.

HB 6557, favorably reported by the Program Review and Investigations Committee, has a number of provisions that are similar or identical to those in this bill. Among other things, it (1) treats as urgent, requests for treatments of substance use co-occurring disorders, (2) generally requires carriers to make determinations for urgent care requests for inpatient substance use disorder treatment within 24 hours, and (3) expands notice requirements for carriers making an adverse determination. HB 6557 also establishes additional qualification requirements for clinical peers who review adverse determinations.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 0 (03/19/2013)